

LIST OF NORDHOFF CHIROPRACTIC OFFICE FORMS

FORM #	DESCRIPTION	FORM #	DESCRIPTION
	"FORM 2000A"		"FORM 2000C" CONTINUED
1000	Patient Introduction Form (Cash-Ins cases)	3242	Sports-Recreational-Home Injury
1010	General Health History (2 pages)	3300	Request for Medical Records
1020	Headache-Migraine Questionnaire	3310	Bill for Reports/Copying
1030	Symptom Questionnaire (Neck-Mid Back)	3320	Pre-Payment Request for Reports/Copying
1040	Symptom Questionnaire (Low back-Leg)	3400	Chiropractic Report to Patient
1050	Post-traumatic Symptom Questionnaire	3500	Examination Form-Comprehensive (4 pages)
1060	Head Injury Questionnaire	3510	Examination Form-Brief
1070	Concussion Questionnaire	3600	Non-Injury History and Consultation Form
1080	Symptom Intensity & Frequency Form	3610	Post-Injury History and Consultation Form
1090	Before & After Injury Comparison Form	3620	History Form
1100	Pain Intensity NAS Scale (0-10) Not colored		
1200	Proof of Service by Mail		"FORM 2000D"
1300	Prescription for Medical Supplies		Sample IME worksheet
			Sample PI Report
	PROGRESS AND SOAP NOTES		Appointment Calendar (15 Min)
1500	Front of Travel Card		
1501	Back of Travel Card-Report of findings		
1510	SOAP Notes (complex case)		MISCELLANEOUS FILES
1520	SOAP Notes (noncomplex case)		Informed Consent
1530	Progress Notes		HIPAA Forms for the DC practice
1540	Periodic Progress Notes		Pain/Disability Graph
			Headache Calendar
	"FORM 2000B"		Sign-In Form for Patient
2000	Emergency Room and Disability dates		Color Pain NAS Scale (print on color printer)
2100	List of All Providers Seen (3 pages)		Check Ledger for office
2200	Patient Home Instructions		Spanish Forms (28 pages)
2210	Post Injury Instructions		Radiology Forms
2220	Headache Instruction Form		Medicare Sign In Form & other Medicare forms
2230	Head Injury Home Instruction Form		
2240	Disc Protrusion and Spinal Stenosis		PERSONAL INJURY FORMS
2250	Collar Bone Instruction Form	4000	Personal Injury Introduction Form
2300	Risk Factors for Nontraumatic Back Pain	4010	Motor Vehicle Crash Form (3 pages)
2400	Prescription for Gym Exercise Trainer	4100	Motorcycle Injury Form (2 pages)
2410	Prescription for Massage Therapy	4110	Bicycle Injury Form (2 pages)
2420	Prescription for Physical Therapy	4120	Pedestrian Injury Form (2 pages)
2500	Disability Form (General)	4130	Slip-and-Fall Injury Form
2510	Return to Work Form	4200	Doctor's Lien DC/MD (1 & 2 pages)
2520	Return to Work After Head Injury	4210	Lien Reduction Letter to Attorney
2600	Functional Capacity Questionnaire (2 pages)	4300	Notice of PI Case Closure to Insurance Co
2700	Activity Questionnaire	4310	Notice of PI Case Closure to Attorney
2800	School Activity Exemption-Sports	4400	PI Physician Progress Report (2 pages)
2801	Return to School Activity	4450	Motor Vehicle Collision Injury Report
		4500	Notice of New Injury to Insurance Co
	"FORM 2000C"	4600	Fee Structure for Deposition/Trial Testimony
3000	ICD Codes	4610	Case Worksheet for Deposition/Trial
3020	Patient Problem List & Treatment Plan	4620	DC-Attorney Agreement for Deposition
3030	Upper Extremity Disorders-Treatment Plan		
3100	Patient Instruction for Insurance Payment		WORKERS' COMPENSATION FORMS
3110	Factors that have Complicated Recovery	5000	Workers' Compensation Introduction Form
3120	Patient Update Form	5100	Employment Information
3200	Physician Request for Testing	5150	Job Description Information
3210	Physician Request for Supplies		
3230	Physician Referral (work comp)		DOES NOT INCLUDE CALIFWC FORMS
3240	Consultation-Referral Form		

These forms require that the purchaser have Microsoft Word (2003 or newer version) that is IBM compatible.
NOTE: The following forms are examples of what is included on the CD. Some of the forms that are illustrated here are partial pages to provide an overview of these forms. Some only give partial pages.

GENERAL HEALTH HISTORY (Page 1)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	History of poor healing or told that you have a healing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or any other neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment or surgery of any type?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why/When:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure? If yes, name of MD seeing:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of chest or breast implants presently (males & females)?	N/A	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check box to left if there any chance that you are currently pregnant		<input type="checkbox"/>

If you checked yes, please describe:

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

NO. (Check box if you have no prior history of previous injury or pain) If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

NO. (Check box if you have never had any broken bones in the past). If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

NO. (Check box if you never had any surgical procedure). If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe surgery and date:

Indicate when you have your last physical examination by a medical doctor and please indicate his/her name?	Doctor: Date:
---	------------------

Patient Name:	Doctor's Name: Lawrence Nordhoff, DC
---------------	--------------------------------------

Form 1010

GENERAL HEALTH HISTORY (Page 2)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses

No, Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, or other diseases?

If yes, please describe:

No, Yes **Have you ever been to a Chiropractor before for any condition?**

If yes, Chiropractor's Name/City : _____ Year: _____

List Problem(s) that the Chiropractor treated you for: _____

No, Yes **Do you have any problems laying face down on an examination table** (tender breasts, chest or breast surgical implants, ports, etc)? If yes, why: _____

MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

No, Yes **Are you taking any medications currently?** In yes, list all medications that you are taking:

No, Yes. **Have you taken any pain medications today? If yes, describe:** _____

FOOD OR MEDICATION ALLERGY HISTORY

No, Yes . Do you have allergies to any medications, foods, herbs, shellfish, seafood, etc? If yes, List:

DESCRIBE YOUR TYPICAL EXERCISE ROUTINE CURRENTLY

Describe what types of exercise you perform:

How often to do your regularly exercise:

SYMPTOM OR COMPLAINT ONSET

Suddenly, Gradually. Check box indicating if your current symptoms developed gradually or suddenly.

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

YES NO SLEEPING PATTERNS

<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep poorly at night?
<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep on your stomach?
<input type="checkbox"/>	<input type="checkbox"/>	Do you consistently feel extremely tired when you wake up in the morning?

Patient Name:

Doctor's Name: Lawrence Nordhoff, DC

Form 1010

NECK, BACK, SACRUM, PELVIS PAIN AND/OR INJURY HISTORY (Page 3)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES NO GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)

<input type="checkbox"/>	<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
<input type="checkbox"/>	<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine?
<input type="checkbox"/>	<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
<input type="checkbox"/>	<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had previous head injury (e.g., blow or fall)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever injured your neck, back, sacrum or pelvis?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

NECK PAIN AND/OR INJURY HISTORY

Location of your pain (left, right, middle, both sides):	
When did your neck pain begin and/or injury occur?	Date required:
Describe how or why your pain began(mechanism): Describe any neck injury (what happened):	
Describe all aggravating physical activities/motions: (What activities/motions that make your pain worse)	
Describe any relieving physical activities: (What activities lessen your neck pain)	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, numbness, tingling, stiff, etc):	
Describe any symptoms that originate from your neck that radiate down to your shoulders/arms/hands?	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your neck before?	

YES NO NECK REGION HISTORY CONTINUED

<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?

Patient Name: Sally Jones	Doctor's Name: Lawrence Nordhoff, DC
---------------------------	--------------------------------------

Form 1010

THORACIC, LUMBAR, SACRUM, PELVIS REGION HISTORY (Page 4)

Location of your pain (left, right, middle, both sides):	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism): Describe any injury (what happened):	
Describe all aggravating physical activities/motions: (What activities/motions make your pain worse)	
Describe any relieving physical activities: (What activities lessen your pain)	
Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, numbness, tingling, stiff, etc):	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your back before?	

YES NO THORACIC AND BACK REGION HISTORY CONTINUED

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like feeling sometimes around your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	When you move your neck around, does your middle back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
<input type="checkbox"/>	<input type="checkbox"/>	Does either leg or foot drag on the floor when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a lot of leg cramps at night recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Does one or both of your legs feel weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb?

Please print clearly

If yes, describe and indicate dates:

Patient Name: Sally Jones	Doctor's Name: Lawrence Nordhoff, DC
---------------------------	--------------------------------------

Form 1010

PATIENT PROGRESS NOTES

DATE	S	See Pain Drawing. <input type="checkbox"/> H/A, <input type="checkbox"/> Nk pn, <input type="checkbox"/> MB pn, <input type="checkbox"/> LBP, <input type="checkbox"/> SI pn, <input type="checkbox"/>
	O	Pain-Tenderness with palpation: Asymmetry ROM Tissue Tone Abnormalities
	A	<input type="checkbox"/> Responding (Normally/Slowly/No improvement). ADLs/Function
Dr. Signature	P	<input type="checkbox"/> See ____ times a week/mo. <input type="checkbox"/> See PRN. <input type="checkbox"/> Cerv tract ____ min ____ lbs, <input type="checkbox"/> Muscle Stim ____ min, <input type="checkbox"/> Ice, <input type="checkbox"/> <input type="checkbox"/> CMT: <input type="checkbox"/> Nk ____, <input type="checkbox"/> MB ____, <input type="checkbox"/> LB ____, <input type="checkbox"/> SI, Other: ____ <input type="checkbox"/> Mobilization <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other: <input type="checkbox"/> Myotherapy ____ min (gentle/deep) to areas noted in objectives <input type="checkbox"/> Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min: Frequency of future treatment: <input type="checkbox"/> will continue as set in initial plan, <input type="checkbox"/> frequency changed (explain):

These have 2 dates per page.

CMS-MEDICARE PATIENT PROGRESS NOTES

DATE	S	Pain Intensity (0-10). ____ Pain levels: (better/same/worse than last visit) List ADL functional activities that are better/same/worse.
Manipulation <input type="checkbox"/> Acute Treatment 98940-AT 98941-AT <input type="checkbox"/> Maintenance Care 98940-GA Non-Manipulation <input type="checkbox"/> -GY -GZ	O	Pain-Tenderness with palpation: Asymmetry ROM Tissue Tone Abnormalities
	A	Asses change in pts condition (function, posture, etc) Patient response to manipulation: (better/same/worse)
Signature: Lawrence Nordhoff, DC	P	CMT to _____ subluxations. <input type="checkbox"/> Mobilization <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other: <input type="checkbox"/> Myotherapy (gentle/deep) to areas noted in objectives <input type="checkbox"/> Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min: Frequency of future treatment: <input type="checkbox"/> will continue as set in initial plan, <input type="checkbox"/> frequency changed (explain):

MOTOR VEHICLE COLLISION FORM

Patient Name: _____		Date: _____	
Date of crash: _____		Time of collision: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
City where crash occurred: _____		Was the street wet or dry? <input type="checkbox"/> Wet <input type="checkbox"/> Dry	
Street (location) where crash occurred: _____			
Who owns the vehicle in which you were hit? _____			
What is the estimated repair damage to your vehicle? \$ _____ <input type="checkbox"/> Unknown, <input type="checkbox"/> Estimate not done yet			
How many people were in your vehicle at the time of the crash? _____			
<input type="checkbox"/> Yes, <input type="checkbox"/> No Did the police come to the crash scene?			
<input type="checkbox"/> Yes, <input type="checkbox"/> No Did the police make a written report?			
<input type="checkbox"/> Yes, <input type="checkbox"/> No Were any photographs taken of the vehicles? If yes, who took them?			

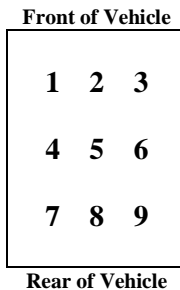
DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

<input type="checkbox"/> Single-vehicle crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three-or-more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on or frontal crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

CIRCLE YOUR SEATING POSITION (The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.)



DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door

Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat bent or damaged	<input type="checkbox"/> Dash or area around knee/foot
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side or rear window broken	<input type="checkbox"/> Other

Describe Damage:

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did you strike or did any objects or animals within your vehicle hit you during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to a point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the airbag deploying?
<input type="checkbox"/>	<input type="checkbox"/>	Did your seatbelt system require repairs after the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Was the back of your seat that you were sitting in damaged or bent during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and Shoulder Strap, <input type="checkbox"/> Automatic shoulder strap with driver needing to manually attach lap belt, <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any cuts, bruises, or abrasions from the seatbelts?
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (<i>Use time clock face as your reference point</i>) Left hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ___ o'clock, <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ___ o'clock, <input type="checkbox"/> Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

<input type="checkbox"/> Movable/adjustable head restraint	<input type="checkbox"/> Fixed, non-moveable head restraint
<input type="checkbox"/> No headrests in my vehicle	<input type="checkbox"/> Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of crash (if present):

<input type="checkbox"/> At the top of the back of your head	<input type="checkbox"/> Midway height of the back of your head
<input type="checkbox"/> Lower height of the back of your head	<input type="checkbox"/> Located at the level of your neck
<input type="checkbox"/> Level of your shoulder blades	

BRUISING AFTER THE CRASH?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):
--------------------------	--------------------------	---

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending crash and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left, <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

Doctor's Name: Lawrence Nordhoff, DC	Patient's Name: Sally Jones
--------------------------------------	-----------------------------

Form 4010

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS RECENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				

Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name: Lawrence Nordhoff, DC	Patient Name: Sally Jones
--------------------------------------	---------------------------

(Report of Findings)

PROBLEM LIST	ETIOLOGY	TREATMENT RENDERED
<input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Neck pain/soreness/stiffness <input type="checkbox"/> Middle back pain/soreness <input type="checkbox"/> Chest wall pain <input type="checkbox"/> Low back pain/soreness <input type="checkbox"/> Hip/Sacroiliac joint pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Calf/ankle/foot pain <input type="checkbox"/> Rotator Cuff Syndrome <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Elbow/forearm/wrist pain <input type="checkbox"/> Upper extremity pain/paresthesia <input type="checkbox"/> Lower extremity pain/paresthesia <input type="checkbox"/> Radiculopathy <input type="checkbox"/> Biomechanically weak area <input type="checkbox"/> Thoracic Outlet Syndrome <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Strain _____ <input type="checkbox"/> Sprain _____ <input type="checkbox"/> Strain/Sprain _____ <input type="checkbox"/>	<input type="checkbox"/> Recent trauma _____ <input type="checkbox"/> Old trauma _____ <input type="checkbox"/> Joint dysfunction <input type="checkbox"/> Post-traumatic inflammation/swelling <input type="checkbox"/> Zygapophyseal joint/capsule irritation <input type="checkbox"/> Facet Joint/Capsule Inflammation <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Myofascial scar tissue-post traumatic <input type="checkbox"/> Myofascial adhesions, nontraumatic <input type="checkbox"/> Shortening-contracture of muscle <input type="checkbox"/> Active trigger points <input type="checkbox"/> Postural-Ergonomic muscle tension <input type="checkbox"/> Meniscoid entrapment (synovial fold) <input type="checkbox"/> Disc Annular fiber injury <input type="checkbox"/> Bulging/herniated cervical disc <input type="checkbox"/> Bulging/herniated lumbar disc <input type="checkbox"/> Peripheral nerve root compression <input type="checkbox"/> Degeneration of discs <input type="checkbox"/> Degeneration of joints (osteoarthritis) <input type="checkbox"/> Scapular winging, dorsal weakness <input type="checkbox"/> Weak low back/abdominal muscles <input type="checkbox"/>	<input type="checkbox"/> Spinal adjustments <input type="checkbox"/> Extremity adjustments <input type="checkbox"/> Joint mobilization <input type="checkbox"/> Myotherapy (gentle/deep) _____ min Areas: <input type="checkbox"/> Therapeutic exercises <input type="checkbox"/> Cervical/Lumbar traction ___ lbs, ___ min <input type="checkbox"/> Muscle Stim ___ setting for ___ min <input type="checkbox"/> Ice packs/ Moist heat packs (home/office) <input type="checkbox"/> Exercises (home/gym/office) ___ x week <input type="checkbox"/> Stretching (home/gym/office) ___ x week <input type="checkbox"/> Dietary/Nutritional advice _____ <input type="checkbox"/> Posture modifications _____ <input type="checkbox"/> Ergonomic modifications _____ <input type="checkbox"/> Cervical collar <input type="checkbox"/> Cervical pillow <input type="checkbox"/> Brace (wrist etc) _____ <input type="checkbox"/> Lumbar brace <input type="checkbox"/> Orthotics _____ <input type="checkbox"/>

TREATMENT OBJECTIVES

<input type="checkbox"/> Decrease pain/paresthesias <input type="checkbox"/> Enhance and improve repair <input type="checkbox"/> Decrease swelling/inflammation <input type="checkbox"/> Improve and normalize joint motion <input type="checkbox"/> Improve circulation to joint	<input type="checkbox"/> Break up myofascial adhesions <input type="checkbox"/> Neutralize active trigger points <input type="checkbox"/> Lessen impingement <input type="checkbox"/> Strengthen weak areas <input type="checkbox"/> Get pt reliant on self-management <input type="checkbox"/>	<input type="checkbox"/> Stabilize condition <input type="checkbox"/> Improve body-joint function <input type="checkbox"/> Improve posture/ergonomics <input type="checkbox"/> Prevent or lessen risk of chronicity <input type="checkbox"/> Avoid surgery
---	--	--

NOTES: _____

X-ray necessity:	<input type="checkbox"/> Yes, indicated, <input type="checkbox"/> Not indicated. Will wait and observe response first before ordering x-rays.
Complicating factors:	<input type="checkbox"/> None noted, <input type="checkbox"/> Yes:
Referral for testing or to a MD:	<input type="checkbox"/> None noted, <input type="checkbox"/> Yes, indicated:

INITIAL OFFICE VISIT FREQUENCY (ESTIMATE)	<input type="checkbox"/> Daily, <input type="checkbox"/> 4-5x wk, <input type="checkbox"/> 3x wk, <input type="checkbox"/> 2x wk, <input type="checkbox"/> 1x wk for ____ week(s), then patient will be re-evaluated. Based on exam findings and response to treatment, the visit frequency will then be determined. Will re-evaluate pt in _____ weeks.
--	--

<input type="checkbox"/> Condition outlined to patient	<input type="checkbox"/> Treatment objectives explained	<input type="checkbox"/> Pt willing to do home recommendations.
--	---	---

Travel Card-Progress Notes Abbreviations: adj = adjustment, MH = moist heat, Elect Stim = Electrical Stimulation, US = Ultrasound, mm = muscle, H/A = headache, Nk pn = neck pain, MB pn = middle back pain, UB pn = upper back pain, SI = Sacroiliac, Sh = shoulder, cerv tract = cervical traction, TP = trigger point, Tx = treatment, ThEx = Therapeutic exercises, MT = manual therapy, Flex-Dist = Flexion-Distractioin, Int traction = intersegmental traction, mm = muscle, wk = week.

Patient Name:	Doctor's Name/Address:

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

①	Name Emergency Room, hospital/doctor/therapist/center: _____	
Address: _____		Date: _____
Indicate what was done:		
<input type="checkbox"/> Exam-consultation <input type="checkbox"/> Exam or consult only (no treatment) <input type="checkbox"/> X-ray of neck or head <input type="checkbox"/> X-ray of chest/ribs/middle back <input type="checkbox"/> X-ray of low back/ pelvis/hips <input type="checkbox"/> X-ray of shoulder/arms/legs <input type="checkbox"/> MRI/CT scan <input type="checkbox"/> EMG/Nerve conduction study <input type="checkbox"/> Other tests	<input type="checkbox"/> Rehabilitation <input type="checkbox"/> Ultrasound <input type="checkbox"/> Spinal adjustments <input type="checkbox"/> Muscle massage/myotherapy <input type="checkbox"/> Muscle stimulation <input type="checkbox"/> Physical therapy <input type="checkbox"/> Anti-inflammatory medications <input type="checkbox"/> Pain medications <input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Exercises <input type="checkbox"/> Acupuncture <input type="checkbox"/> Injection(s) <input type="checkbox"/> Wrist brace-splint <input type="checkbox"/> Neck collar (brace) <input type="checkbox"/> Low back brace <input type="checkbox"/> Heat packs <input type="checkbox"/> Ice packs <input type="checkbox"/> Other: _____
Indicate if treatment with this provider: <input type="checkbox"/> Helped, <input type="checkbox"/> Did not help, <input type="checkbox"/> Made condition worse		

ICD CODE WORKSHEET

	HEAD/HEADACHE-TMJ		THORACIC SPINE		LUMBAR SPINE
850.0	Mild Concussion (No LOC)	353.0	Thoracic Outlet Syndrome	353.0	Lumbosacral Plexus Lesion
850.11	Mild Concussion (Brief LOC <30 min)	353.3	Nerve root lesion-thoracic	353.4	Nerve root lesion
310.2	Post-Concussion Syndrome	719.08	Edema	355.0	Sciatica Piriformis syndrome
368.8	Blurry Vision, post-traumatic	719.58	Stiffness of joint	719.08	Edema
388.3	Tinnitus	719.68	Joint crepitus	719.58	Stiffness of joint
780.4	Dizziness/Light-headedness	720.1	Spine Enthesopathy	719.68	Joint crepitus
339.21	Acute post-traumatic headache	721.2	Spondylosis w/o myelopathy	720.1	Spine Enthesopathy
339.22	Chronic post-traumatic headache	721.41	Spondylosis with myelopathy	721.3	Spondylosis w/o myelopathy
307.81	Tension Headache	722.0	Spondylosis	721.42	Spondylosis with myelopathy
339.12	Chronic tension H/A	722.11	Disc Displacement w/o myelopathy	722.0	Spondylosis
346.00	Migraine, Classic, With Aura	722.31	Schmorl's Node	722.10	Disc Displacement w/o myelopathy
346.10	Migraine, Common, No Aura	722.51	Degeneration IVD	722.32	Schmorl's Node
784.0	Headache	722.6	Narrowing of disc	722.52	Degeneration IVD
524.60	TMJ Disorder, unspecified	722.71	Disc with myelopathy	722.6	Narrowing of disc
848.1	TMJ strain/sprain	722.83	Post-laminectomy Syndrome	722.71	Disc with myelopathy
		728.85	Muscle spasm	722.83	Post-laminectomy Syndrome
	CERVICAL SPINE	724.01	Spinal Stenosis-thoracic	728.85	Muscle spasm
353.0	Brachial Plexus-TOS	724.1	Thoracic pain	724.02	Spinal Stenosis-Lumbar
353.2	Nerve root lesion	724.4	Thoracic neuritis or radiculitis	724.2	Lumbar pain-Lumbago
719.08	Edema	724.5	Thoracic/Lumbosacral backache	724.3	Sciatica (from disc or other sources)
719.58	Stiffness of joint	724.8	Facet syndrome	724.4	Lumbosacral Neuritis or radiculitis
719.68	Joint crepitus	728.4	Laxity ligament	724.5	Lumbosacral backache unspecified,
720.1	Spine Enthesopathy	728.85	Muscle spasm	724.6	Ankylosis or Sacroiliac disorder
721.0	Spondylosis w/o myelopathy	729.1	Myalgia, Myositis/Myofascitis	724.8	Facet syndrome
721.3	Spondylosis with myelopathy	729.2	Neuralgia or neuritis	728.4	Laxity ligament
722.0	Spondylosis	729.4	Fascitis	728.85	Muscle spasm
722.1	Disc Displacement w/o myelopathy	737.10	Acquired kyphosis	729.1	Myalgia, Myositis/Myofascitis
722.0	Schmorl's Node	737.20	Decreased kyphosis	729.2	Neuralgia or neuritis
722.4	Degeneration IVD	737.30	Scoliosis	729.4	Fascitis
722.6	Narrowing of disc	782.0	Paresthesias (tingling-numbness)	737.20	Acquired lordosis (curve)
722.71	Disc with myelopathy	847.1	Thoracic strain/sprain	737.30	Scoliosis
722.81	Post-laminectomy Syndrome	905.7	Late effects strain/sprain	738.4	Acquired spondylolisthesis
723.0	Spinal Stenosis			756.12	Spondylolisthesis
723.1	Cervicalgia			782.0	Paresthesias (tingling-numbness)
723.3	Cervicalbrachial syndrome		UPPER EXTREMITY	847.2	Lumbar strain/sprain
723.4	Radiculitis/Brachial neuritis (no disc)	840.4	Rotator Cuff strain/sprain	846.0	Lumbosacral strain/sprain
723.5	Torticollis	726.10	Rotator Cuff Syndrome	846.1	Sacroiliac ligament sprain
728.85	Muscle spasm	840.0	AC Joint strain/sprain	905.7	Late effects strain/sprain
724.8	Facet syndrome	719.43	Elbow pain		
728.4	Laxity ligament	841.3	Ulnohumeral joint strain/sprain		
729.1	Myalgia, Myositis/Myofascitis	726.31	Medial epicondylitis		COMPLICATING DISORDERS
729.2	Neuralgia or neuritis	726.32	Lateral Elbow Epicondylitis		Diabetes
729.4	Fascitis	842.00	Wrist strain/sprain		Osteoporosis/Osteopenia
737.10	Acquired kyphosis (curve)	354.0	Carpal Tunnel Syndrome		Congenital spine anomalies
782.0	Paresthesias (tingling-numbness)				Rheumatoid arthritis
847.0	Cervical strain/sprain				Chronic Fatigue Syndrome
905.7	Late effects strain/sprain		LOWER EXTREMITY		Sleep Apnea
		843.0	Ileofemoral strain/sprain		Overweight
		844.0	Lat. Coll. Ligament strain/sprain		Unequal leg length
	MEDICARE SUBLUXATIONS	844.1	Med. Coll. Ligament strain/sprain		Fibromyalgia
739.0	Occ-cervical	844.2	Cruciate ligament sprain		Collapsed vertebrae
739.1	Cervical Region	836.0	Tear medial meniscus		Gastrointestinal disorder
739.2	Thoracic Region	836.1	Tear lateral meniscus		Neurologic disorders
739.3	Lumbar Region	845.01	Deltoid ligament sprain		Muscle or bone disease
739.4	Sacral Region				
739.5	Pelvic Region				www.ICD9Data.com Website verify

Patient's Name :

Doctor's Name : Lawrence Nordhoff, DC

Form 3010

DISABILITY FORM

EMPLOYEE NAME: _____ DATE: _____

This letter/form certifies that this patient is under my care for the following:

<input type="checkbox"/>	Neck or back pain	<input type="checkbox"/>	Automobile crash injury Date: _____
<input type="checkbox"/>	Knee, leg, or foot pain	<input type="checkbox"/>	Work related injury Date: _____
<input type="checkbox"/>	Arm pain	<input type="checkbox"/>	Sports/Home related injury and/or pain
<input type="checkbox"/>	Disc pain	<input type="checkbox"/>	Other: _____

HE/SHE IS PRESCRIBED:

<input type="checkbox"/>	Temporary Partial Disability (See Modifications)	<input type="checkbox"/>	Temporary Total Disability	<input type="checkbox"/>	Permanent Partial Disability (See Modifications)	<input type="checkbox"/>	Permanent Total Disability
--------------------------	--	--------------------------	-----------------------------------	--------------------------	--	--------------------------	-----------------------------------

Modifications/Restrictions include the following:

<input type="checkbox"/>	Single lifting limited to _____ pounds	<input type="checkbox"/>	(No/Limited) fingering/handling/grasping
<input type="checkbox"/>	No repeated lifting over _____ pounds	<input type="checkbox"/>	(No/Limited) bending head-neck
<input type="checkbox"/>	Lifting restricted to _____ times per hour	<input type="checkbox"/>	Keyboarding limited to _____ (minutes/hours) per day
<input type="checkbox"/>	No lifting above (waist/shoulder/head) level	<input type="checkbox"/>	Sitting limited to _____ (minutes/hours) per day
<input type="checkbox"/>	No raising/lowering objects to other levels	<input type="checkbox"/>	(No/Limited) carrying activity
<input type="checkbox"/>	(No/Limited) bending/stooping waist	<input type="checkbox"/>	To take a _____ minute break every _____ hours
<input type="checkbox"/>	(No/Limited) crouching/squatting	<input type="checkbox"/>	Allow worker to move about when needed for pain
<input type="checkbox"/>	(No/Limited) twisting/pushing/pulling	<input type="checkbox"/>	Limited to _____ hours of work per day
<input type="checkbox"/>	(No/Limited) climbing/crawling	<input type="checkbox"/>	To wear a _____ (support/brace) at work
<input type="checkbox"/>	No (walking/standing)	<input type="checkbox"/>	
<input type="checkbox"/>	No prolonged walking/standing	<input type="checkbox"/>	

ACTIVITIES OF DAILY LIVING RESTRICTIONS-MEDICARE

PATIENT NAME: _____ DATE: _____

INSTRUCTIONS FOR PATIENTS: Please write in all physical activities for each of the following sections that you are having difficulty performing or that you cannot perform at the time of your initial consultation. The chiropractor needs to identify specific restrictions or disabilities that only relate to your neck, middle back, low back, and pelvic regions. It is important to not include any restrictions or disabilities that you have that relate to other body regions, such as your arms and legs. If not employed please indicate "N/A." If able to perform all activities in a specific section please indicate "None." For example: if you do not participate in any sport activities you would indicate "None."

WORK ACTIVITIES (Please write in all work activities that you have difficulty or inability performing recently):

Which work activity is most difficult to perform: _____

HOME ACTIVITIES (Please write in all home activities that you have difficulty or inability performing recently):

Which home activity is most difficult to perform: _____

RECREATIONAL ACTIVITIES (Please write in all hobby-recreational activities that you have difficulty or inability performing recently):

Which hobby-recreational activity is most difficult to perform: _____

SPORT ACTIVITIES (Please write in all sport activities that you have difficulty or inability performing recently):

Which sport activity is most difficult to perform: _____

Patient Name:	Doctor: Lawrence Nordhoff, DC 4133 Mohr Ave, Ste F, Pleasanton, CA 94566
---------------	---

PATIENT NAME: _____ DATE: _____

MEDICARE SUBLUXATION EXAMINATION FINDINGS

LEFT SIDE OF BODY

RIGHT SIDE OF BODY

Muscle Spasm	Tissue Tone	Range-of-Motion	Asymmetry	Pain Tenderness	LEVEL	Pain Tenderness	Asymmetry	Range-of-Motion	Tissue Tone	Muscle Spasm
					Occ					
					C1					
					C2					
					C3					
					C4					
					C5					
					C6					
					C7					
					T1					
					T2					
					T3					
					T4					
					T5					
					T6					
					T7					
					T8					
					T9					
					T10					
					T11					
					T12					
					L1					
					L2					
					L3					
					L4					
					L5					
					Sacral					
					Pelvis					

+ Mild, ++ Moderate, +++ Severe (Findings from Palpation-ROM testing-X-ray). Circled vertebra: indicates subluxation level

FORMULARIO DE INTRODUCCION DEL PACIENTE

Nombre del Paciente:	Fecha de Hoy:
Direccion:	Teléfono de la Casa:
Ciudad/Codigo Postal:	Teléfono del Trabajo:
Fecha de Nacimiento:	Edad:
Estatura:	Ocupacion:
Peso:	Empleo:
Licencia de Manejar Num.:	Seguro Social Num.:

LA VISITA ESTA RELACIONADA CON:

- | | |
|--|---|
| <input type="checkbox"/> Lesion Relacionada con el Trabajo | <input type="checkbox"/> Lesion de Accidente Automovilístico |
| <input type="checkbox"/> Lesion Relacionada con la Casa | <input type="checkbox"/> Lesion por un Deporte |
| <input type="checkbox"/> Síntomas Sin Lesiones | <input type="checkbox"/> Revision General Solamente |
| <input type="checkbox"/> Lesion por Caída o por Resbalar | <input type="checkbox"/> Exámen Físico requerido por la Escuela |

MUJERES SOLAMENTE

Sí, No ¿Hay posibilidad que esté embarazada ahora o sospeche estar embarazada?

INFORMACION DEL SEGURO MEDICO

Sí, No ¿Tiene usted seguro que cubra un tratamiento Quiropráctico?

Nombre y Direccion de la Compañía de Seguro: _____

¿Es usted el asegurado, o dependiente?

¿Cuál es el porcentaje que pagan? _____

¿Cuál es la cantidad del deducible? _____

¿Limitan la cantidad de pago por cada visita? _____

¿Limitan el numero de visitas? _____

Nuestra oficina mandará como cortesía la factura a su compañía aseguradora. Si usted tiene una poliza de seguro secundaria, es su responsabilidad mandarles la factura. Tendrá que pagar por todo lo que su compañía de seguros principal no pague. Su segunda compañía aseguradora le pagará después, basado en los beneficios de su poliza.

Si usted lo desea, nuestra oficina le proveerá los servicios para mandar las facturas. *Recuerde que usted es responsable por cualquier cargo incurrido en esta oficina. Es su responsabilidad pagar cualquier deducible, y cualquier otro balance que no sea pagado por su compañía de seguros.*

PARA DE MANTENER BAJOS LOS GASTOS EN NUESTRA OFICINA Y LAS CUOTAS RAZONABLES, SE REQUIERE EL PAGO AL FINAL DE CADA TRATAMIENTO PARA NUESTROS PACIENTES QUE PAGUEN EN EFECTIVO Y LA PARTE DE PAGO CORRESPONDIENTE PARA LOS PACIENTES REGULARES CON SEGURO MEDICO.

Firma de la parte responsable (Paciente o Padres): _____ Fecha _____

(Doctor's Name/Address/Telephone)

